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Intergovernmental relations, social policy and federal transfers after Romanow

Abstract: This article explores the new and old intergovernmental dynamics around federal transfers to the provinces for health and social policy spending in the aftermath of the Romanow report and the decision to split the Canada Health and Social Transfer (CHST) into its two component parts. Though the provinces have agreed to the split, the federal government undertook the allocation of the transfer to the new Canada Health Transfer and the Canada Social Transfer unilaterally. At the same time, the federal government has simultaneously been increasing its own social spending in areas of provincial jurisdiction in recent years. In response, the provinces have been taking an increasingly hard line towards Ottawa's unilateral actions, as demonstrated by the creation of the Council of the Federation and its focus on the so-called fiscal imbalance in the federation. These dynamics make the intergovernmental commitment to collaborative federalism ring somewhat hollow. The article argues that the inability of both orders of government to take collaborative federalism and policy interdependence seriously poses significant threats not only to the health of the federation but also to efforts to create healthy public policy.

Sommaire : Le présent article porte sur les nouvelles et anciennes dynamiques intergouvernementales concernant les transferts accordés par le fédéral aux provinces pour le financement des politiques sociales et de santé, qui ont découlé du Rapport Romanow et de la décision de scinder le Transfert canadien en matière de santé et de programmes sociaux (TCSPS) en deux composantes distinctes. Quoique les provinces aient accepté la scission, le gouvernement fédéral a entrepris de procéder unilatéralement à l'affectation des paiements aux nouveaux Transfert canadien en matière de

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santé et Transfert canadien en matière de programmes sociaux. Simultanément, ces dernières années, le gouvernement fédéral a accru ses propres dépenses sociales dans des domaines de juridiction provinciale. Face à cela, les provinces ont adopté une position de plus en plus intransigeante à l'égard des initiatives unilatérales d'Ottawa comme le démontrent la création du Conseil de la fédération et sa concentration sur le soi-disant déséquilibre financier au sein de la fédération. Cette dynamique fait que l'engagement intergouvernemental envers le fédéralisme de collaboration sonne plutôt vide. L'article soutient que l'inaptitude des deux ordres de gouvernement à prendre au sérieux le fédéralisme de collaboration et l'interdépendance politique représente une forte menace, non seulement pour la santé de la fédération, mais aussi pour les efforts visant à créer un politique publique saine.

In its final report, the Commission on the Future of Health Care in Canada, headed by former Saskatchewan Premier Roy Romanow, recommended that, beginning in 2005–06, the Canadian Health and Social Transfer (chst) be split into two separate all-cash transfers, one for health care and one for both postsecondary education (pse) and social policy spending.[1] This somewhat fundamental rethinking of federal transfers to the provinces received relatively little media coverage and virtually no comment from either federal or provincial government politicians at the time of the report's release. While the minutiae of fiscal federalism and the complexity of the debate over federal transfers to the provinces hardly makes for easy reporting, one might have thought that a recommendation designed to clarify the seemingly endless debate over "how much does the federal government contribute to health care?" would be worthy of more sustained analysis. This is especially so given the unprecedented degree of media coverage accorded the release of the Romanow report generally (coverage that prompted one print journalist to rename the cbc the "Romanow Broadcasting Corporation" for its saturation coverage of the event on television).

Yet the lack of public discussion about this aspect of the Romanow Report has not meant that the recommendation has been ignored. The 2003 First Ministers' Accord on Health Care Renewal was agreed to by eleven of the fourteen first ministers (the three territorial leaders having opted to not accept the document over the lack of attention paid to rural, remote and northern health-care issues) and included a commitment that "The Government of Canada will establish a new long-term Canada Health Transfer (cht) by March 31, 2004. It will include the portion of the current chst (both cash and tax points) corresponding to the current proportion of health expenditures in provincial social spending supported by this transfer. In establishing the cht, the federal government will ensure predictable annual increases in health transfers."[2]

This commitment, though, is unsatisfactory for a number of reasons. First, the federal government continues to include the value of the tax points originally transferred over a quarter century ago into the value of the transfer –

furthering a debate that is as unnecessary as it is unhelpful. Second, the federal government appears uninterested in reinstating an escalator clause into the transfer formula. Thus, the federal government alone will continue to determine the promised predictable increases, and there is no commitment that "predictable" will also mean "sufficient." Third, the federal government appears to be heading towards a unilateral decision regarding how the transfer will be divided between the "health care" and the "social" components that will be designed to maximize their ability to convince the public that they are providing adequate support to medicare despite the fact that their allocation formula is not generally accepted by the provinces.

All of this belies the government's commitment to real collaboration between the orders of government and sets the stage for further federal–provincial conflict. Furthermore, it reinforces the belief among some observers that all this talk of collaborative federalism is itself a means to subordinate the federal principle to the national government's conception of what constitutes good policy.

Indeed, the events that have transpired since the signing of the Health Accord – the 2003 budget, the creation of the Council of the Federation by the provinces, the appointment of a national health council (over the objections of one province and with the non-participation of another), and the 2004 Speech from the Throne – provide further evidence that, whatever the rhetoric, the federal and provincial governments appear to be no more committed to a collaborative model of federalism that respects *both* the division of powers *and* the reality of policy interdependence than they were during the worst of the intergovernmental wrangling in the past decade. Thus, the new Martin administration appears poised to repeat many of the errors of the Chrétien government with regard to intergovernmental relations.

This article, then, is concerned with explicating these intergovernmental dynamics – both new and old – that appear to be moving the country down the same old path. First, the manner in which the federal government handles the creation and allocation of the new transfer can play into the hands of those provinces that are least interested in real collaboration. It does this not only by ignoring provincial concerns over the allocation of the chst between its component parts through unilateral decisions but by also continuing to play up the 1977 tax-point allocation as an ongoing federal transfer. All of this only reinforces the belief among some provinces of the need to address the so-called "fiscal imbalance" through a second permanent transfer of tax points that would effectively remove the federal government from all but the margins of health and social policy. This would, it is argued, not only have negative policy consequences but would also bode ill for the health of the federation. Unfortunately, it also becomes an increasingly attractive option for some provinces in the face of overt federal unilateralism on these issues.

Second, as illustrated by both the 2003 budget and the 2004 Speech from the Throne, the federal government appears to be ramping up the recent trend of direct federal social spending aimed at increasing transfers to individuals – often over the objection of provincial governments – in a unilateral attempt to stake out a new federal role in social policy. This amounts to poking the provinces in the eye with a stick while simultaneously mouthing platitudes about collaboration and cooperation. Again, this is a process that undercuts attempts to create both a healthy public policy and a healthy federation.

The provincial response to this increasingly hollow rhetoric around collaborative federalism and the increased federal spending in provincial jurisdictions may well be found in the new Council of the Federation – a body designed, it seems, to strengthen provincial resolve to "take on" Ottawa over transfers and roles – and in the less than auspicious launch of the national health council. In this sense, then, those who have been critical of all of this "collaborative federalism" talk by the federal government are correct. Over the past decade, by choosing to ignore the constraints that real collaboration should impose on unilateral action in favour of its own definition of what constitutes "good" policy, the federal government has ably demonstrated that it does not really understand what collaboration entails.

But this should not lead us to conclude that collaborative federalism is either impossible or undesireable, only that it is difficult. Alain Noël, perhaps the most articulate of the critics of so-called collaborative federalism as practised in recent years, has argued that the federal government has consistently used the idea that "what works for Canadians" in terms of policy goals and outcomes can and should trump the division of powers inherent in any federal system.[3] Thus, in Noël's view, the federal government justifies its unilateral actions and its intrusions into provincial jurisdiction by arguing that Canadians are interested only in outcomes and do not really care that deeply about the niceties of federalism (a view echoed in the 2004 Speech from the Throne[4]). Noël has characterized the federal government's understanding of collaboration as being one where – having perhaps agreed on the destination – the federal government steers while the provinces row. This, he argues, shows a profound misunderstanding of both the principles of federalism and the meaning of collaboration.

In an era of both globalization and of what Thomas Courchene called "glocalization,"[5] there is no denying the need for governments in federal systems to find processes that encourage collaboration and cooperation between orders of government. Indeed, an expansive, and nuanced, understanding of the complexity of managing intergovernmental relations in federal states can be found in Ronald Watts' assertion that federations must manage policy files not only independently but also interdependently:

[T]here are two important aspects [to effective intergovernmental relations]: one is the establishment of *intergovernmental* structures and processes facilitating consultation, coordination, joint decision-making and conflict resolution among governments; the other is the development within each government of *intragovernmental* structures and processes enabling each government to coordinate its own relations with other governments so as to participate effectively in its interaction with other governments.[6]

And it is not the case that critics of collaborative federalism would disagree with Watts' argument so much as they would lament the willingness of, in particular, the federal government to undercut the development of those intergovernmental institutions through unilateral actions – especially through the use of the spending power – to achieve policy goals and political advantages that real and meaningful collaboration, at least in the short term, denies it.[7]

Overt unilateralism: from the CHST to the Romanow report to the CHT

The unilateral imposition of the chst was the culmination of an ongoing process of federal withdrawal from spending commitments to the provinces that limited its own fiscal flexibility. Of course what is remembered most clearly about the introduction of the chst was the dramatic decline in the cash component of the transfer from just under $18.5 billion in 1995–96 to $14.7 billion the following year. The cash component of the transfer did not approach the 1995–96 level again until 2000–01.[8] But the decline in the cash transfer is only part of the story. What further distinguished the chst from its predecessors, Established Program Financing (epf) and the Canada Assistance Plan (cap), was the exclusion of any built-in escalator formula for the cash portion of the transfer. Thus, not only did the provinces see a significant cut in the cash portion of the transfer under the chst, growth in the cash portion was determined solely by federal largesse and in accordance with federal fiscal priorities.

This had at least two key consequences. The first was the creation of an increasingly fractious intergovernmental climate whereby premiers – at both the annual meetings of the premiers and at the irregularly scheduled first ministers meetings – demanded increases in chst cash from the prime minister. The second effect was to force provinces to plan social spending without adequate knowledge of what may or may not be forthcoming from the federal government. According to the provinces, the federal government was balancing its budget on the backs of the provinces by withdrawing from its previous commitments to fund social spending. From the federal perspective, the provinces wanted increased federal transfers in order to satisfy their own cost-cutting and tax-reduction plans.[9]

At the same time, a new wrinkle was added to these debates – one that would only further confuse the public as it tried to discern fact from fiction. As the provinces complained about the reduction in the cash transfers, the federal government responded by drawing attention to the value of the tax points originally transferred to the provinces in 1977 and including these as part of its "annual" transfer to the provinces. But as Harvey Lazar, France St-Hilaire and Jean-François Tremblay have recently argued (in an analysis originally undertaken on behalf of the Romanow Commission), this is at best misleading and at worst dishonest.[10] In short, the tax points, upon their transfer, became a provincial revenue source and, as such, should not be seen as an annual transfer from the federal government. Of course, in accepting this transfer of tax points, the provinces also should have accepted that they were no longer entitled to the so-called "fifty-cent dollars" for health and social program spending[11] – a corollary that most provinces have conveniently forgotten.

Thus, when the provinces argue – as they have in television advertisements designed to embarrass the federal government – that the federal government now only pays fourteen per cent of health-care costs but used the pay fifty per cent, they are, in effect, deliberately misleading the Canadian public. It is true that the cash component of the chst covers somewhere between fourteen and twenty per cent of the cost of health care – depending entirely on whose numbers you use and how the transfers are allocated – but the claim that this is a decline from fifty per cent ignores the fact that the provinces willingly accepted the tax-point transfer in lieu of cash. This was the rationale, then, for the Romanow Commission's argument that, if the tax points are provincial revenue and not a federal transfer, then provinces have to acknowledge that in accepting the tax transfer they accepted a new formula for calculating the appropriate federal cash transfer. From 1977 on, the "medicare bargain" agreed to was, to put it simply, fifty per cent paid by the provinces, twenty-five per cent paid in cash by the federal government, and twenty-five per cent paid by tax points transferred (which are now, of course, provincial own-source revenue).[12]

Even so, it cannot be denied that reductions in federal cash transfers reduced the flexibility of provincial governments, almost all of which (with varying degrees of enthusiasm) had also promised their electorates lower taxes, balanced budgets and reduced debt loads. This increased the pressure on provincial governments to at least try to maintain health-care spending levels and to find the money to finance tax cuts from other spending envelopes, be it from social programming or the delay and/or cancellation of capital spending or infrastructure investments.

The end-result of the chst's introduction at a time when governments across the country began to reorient their political priorities towards deficit and debt reduction was the development of an increasingly dysfunctional

intergovernmental regime centred on blame avoidance and finger-pointing and punctuated by unilateral federal action.[13] Thus, each order of government attempted to reassure the public that their growing frustration with the state of the nation's health-care system[14] was the fault of actions by the other order of government.

It can be argued, however, that one of the unintended outcomes of the creation of the chst was that it recognized – at least at the level of funding – that the historic distinction between "health-care" spending, "education" spending and "social" spending was inherently false. By integrating the federal contribution to these spending areas, the transfer appears to recognize something that policy analysts and researchers had known for a long time: that all of these programs contributed to the overall health of the population. The point was not to get "health policy" right or "social policy" right but rather to insure that all public policy was itself "healthy."

The chst, as a block transfer with few real conditions on spending and no formal requirement to spend any particular proportion of the money on any particular program, should have provided an impetus to provinces to think more broadly about the overall intent of social policy spending and the flexibility to focus more resources on the social and economic determinants of health – what population health researchers call the "non-medical determinants of health" (nmdh). We have known for a long time that what makes a population "healthy" is not merely access to health care but access to education, affordable housing, "good" jobs, and a clean environment in a social structure with low levels of inequality between citizens.[15]

Unfortunately, the decline in the federal cash contribution left provinces with difficult policy choices. These were generally resolved in favour of sustaining health-care funding (though trying to restrain its growth) while also proceeding, in varying degrees, with the promised tax cuts and the balancing of provincial budgets. One of the brutal truths for policy relating to the nmdh is that in a direct head-to-head competition for resources, short-term health-care spending will almost certainly triumph over the longer-term gains generally associated with spending on the nmdh. Thus, other social and education programs – often those programs aimed at some of society's more vulnerable members – felt the brunt of provincial spending cuts. This was despite the fact that the adoption of population health and healthy public-policy perspectives has been given significant rhetorical endorsements in provincial health reports such as in Saskatchewan's Fyke Commission report, Alberta's Mazankowski report, and Quebec's Clair report.[16]

Consequently, if one wants the nmdh to move closer to the centre of governments' policy agenda, then it makes sense to, in effect, protect those social policy dollars from being cannibalized by health-care spending. It is not surprising, then, that in the interests of improving the transparency of "where do health-care dollars come from and where do they go to" and of

insuring that sufficient funds are dedicated to nmdh-spending, that the Romanow report recommended the creation of two separate federal transfers, with one dedicated to health care and the other to the nmdh – a conclusion shared by the report prepared by the Senate standing committee on social affairs, science and technology as well. But there are important differences between how the two reports structure and finance those dedicated funds.

The Senate committee called on the federal government to create "an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund ... [that would] contain the *additional* revenue raised by the federal government for investment in health care."[17] Further to insisting that the earmarked fund be used exclusively for health care, the Senate committee went on to recommend that the federal government determine an "earmarked revenue source," such as the Goods and Services Tax (gst), that would "fund the approximately 62% of the chst currently regarded as being the federal annual cash contribution to Canada's national health care insurance program."[18] Under the Senate's proposal, the chst would not disappear so much as a component of it would have a dedicated revenue source that would allow the federal government to more closely determine where and how that portion of the cash would be spent by the provinces.

The Romanow Commission took a decidedly different approach in rejecting dedicated or "ear-marked" taxes for health care.[19] In the first instance, the commission recommended the splitting off of an all-cash Canada Health Transfer (cht) from the chst, which, by extension, would also create an all-cash Canada Social Transfer (cst).[20] The cht would continue to be funded from general federal revenues and general taxation as there "continues to be a strong consensus among Canadians that 'ability to pay' should not be the predominant factor in how we fund key aspects of our health care system."[21] But the more important difference between the Romanow Commission's approach and that of the Senate committee revolves around how much of the chst should be considered "health-care money" and how much should be left for other social spending.

Whereas the Senate committee provides no explicit rationale for its contention that sixty-two per cent of the chst is "currently regarded" as the health component, the Romanow Commission provides a detailed appendix outlining the complicated history of federal transfers for health care. Based on that analysis, the Romanow report makes an explicit argument for the return to the traditional allocation for health care under Established Program Financing (epf) of approximately forty-three per cent for Canada Health Act services and fifty-seven per cent for other social spending because

> [i]nvestments that improve the level of education and reduce income disparities can often have a significant long-term impact on the health of the population, thereby

Table 1. *Allocation Formulas for the Cash Base of Proposed Health and Social Transfers, 2001–02*

Allocation formula	*Allocation percentage*	*Hypothetical Canada Health Transfer (cash value, $billion)*	*Hypothetical Canada Social Transfer (cash value, $billion)*
Romanow Commission	43 CHT 57 CST	8.14	10.16
Senate committee	62 CHT 38 CST	11.35	6.95

Source: Adapted from Canada, Commission on the Future of Health Care in Canada [Romanow Commission], *Final Report* (Saskatoon: Commission, 2002), p. 69.

ultimately reducing health care costs. The clear danger in using the higher allocation is that it directly limits the cash available to maintain these other programs. In addressing the apparent deficit in health funding, that deficit should not be passed on to post-secondary education and social assistance.[22]

Perhaps not surprisingly, given their mandates to focus on health care, both the Senate committee and the Romanow Commission are relatively silent about the future of "the other" part of the transfer, what was referred to above as the Canada Social Transfer. Of the $18.3 billion cash component of the chst transferred in 2001–02, the Romanow formula would have resulted in a cst of $10.16 billion (fifty-seven per cent), while the Senate formula would have resulted in a cst of $6.95 billion (thirty-eight per cent).[23] In either case, this remains a significant amount of cash, but obviously more so if one accepts the division proposed by Romanow (see Table 1).

Interestingly, the federal and provincial governments that agreed to the 2003 Health Accord expressed a clear preference for a Romanow-style transfer. That is to say, they have opted for the clear excision of the "H" out of the chst into a separate transfer.[24] But on the issue of how big the respective "H" and "S" are, the federal government appears to have chosen the Senate committee's allocation formula – and done so, as noted below, against the expressed wishes of at least some of the provincial premiers.

There is, of course, an obvious temptation to maximize the size of the cht for both political and policy reasons. As the attention paid to the release of the Romanow Commission's report demonstrates, there is a profound level of interest in the future of the Canadian health-care system. The sustainability of the system (with the attendant concern over wait-times for some elective surgical and advanced diagnostic procedures) and its eventual expansion as envisioned by both Romanow and the Senate committee,[25] have been high on the list of Canadians' key concerns for the better part of a

decade. Canadians have consistently placed a high value on its publicly financed health-care system and continue to express a strong attachment to the values of solidarity and compassion that first motivated its creation.[26] And, as the work of the Citizen's Dialogue project undertaken by the Romanow Commission pointed out, there is a significant degree of willingness by Canadians to contemplate increased taxes to support a reformed and expanded system.[27]

But the concern and attention given to the future of the Canadian health-care system is not matched by equal levels of concern and attention towards other aspects of social policy – even those that both policy analysts and governments have long identified as determinants of population health. There has not been the sustained attention in the media or in the country's legislatures to the problems of the unemployed, the working poor or the homeless that there has been to the issues of waiting lists and access to health care. The same values that are associated with Canadians' attachment to the health-care system (compassion, equity and solidarity) should make Canadians every bit as attached to other social programs aimed at creating employment opportunities or reducing poverty. But the absence of a deluge of media reports and government hand-wringing about the plight of the poor (combined with a persistent distinction between the "deserving" and "undeserving" poor) serves to keep these concerns lower on the public agenda.

Having secured provincial agreement to split the CHST into its component parts ... the federal government appears likely to forge ahead with imposing its own formulation of how the CHST will be split and what it will comprise, namely cash and tax points

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As noted above, the Senate committee provided no explicit rationale for its 62–38 split of the chst. But the federal Department of Finance certainly does. According to documents published in support of the 2003 federal budget, approximately sixty-two per cent of provincial "social spending" on health, social services and postsecondary education goes to health care. Therefore, as the budget documents argue, the appropriate split of the chst is to dedicate sixty-two per cent for health care.[28]

What is left unsaid, however, is that this is a relatively new position on the part of the federal government and one that has no relation to historical allocations made between different portions of federal transfers to the provinces. It appears, therefore, that this particular allocation is based on a clear federal desire to appear to be maximizing its contribution to health-care spending – a choice that may have short-term political advantage but that

Table 2. *Federal Government's Proposed Apportionment of* CHST *to Canada Health Transfer and Canada Social Transfer, 2002–03 to 2007–08 ($billion)*

	2002–03	*2003–04*	*2004–05*	*2005–06*	*2006–07*	*2007–08*
CHST						
Cash	19.10	19.80				
Tax points	16.15	16.95				
CHST *Supplement*		1.00	1.00	0.50		
Health Reform Fund		1.00	1.50	3.50	4.50	5.50
Total	35.25	36.75	2.50	4.00	4.50	5.50
Health transfer						
Cash			12.65	13.00	13.40	13.75
Tax points			11.10	11.70	12.40	13.10
Total			23.75	24.70	25.80	26.85
Social transfer						
Cash			7.75	8.00	8.20	8.45
Tax points			6.80	7.20	7.60	8.00
Total			14.55	15.20	15.80	16.45
Total Cash	19.10	21.80	22.90	25.00	26.10	27.70
Total Tax Points	16.15	16.95	17.90	18.90	20.00	21.10
Total	35.25	38.75	40.80	43.90	46.10	48.80

NOTE: The chst Supplement is $2.5 billion in a third-party trust accounted for in 2002–03 by federal government, and allocations are on assumed draw-downs by the provinces through 2005–06. The value of the cht and cst tax points based on federal government projections.
SOURCE: Adapted from Canada, Department of Finance, *Budget 2003: Investing in Canada's Health Care System* (Ottawa: Her Majesty the Queen in Right of Canada, 2003), Table 5, p. 25.

effectively rewrites (or at least ignores) the historical allocations contained within the chst (see Table 2) and belies the rhetorical commitment to the importance of other kinds of social policy spending.

It is true that, in recent years, provincial governments have been spending larger and larger portions of their provincial revenue on health care. But, as Gerard Boychuk argues, there are multiple reasons for this, including their own commitment to reducing tax rates while trying to limit cuts to health spending, ideological predispositions on the part of some governments to transferring health spending to individuals rather than the state, and the precipitous decline in federal cash transfers in the 1990s that have created a significant "pent-up demand" for health services that provinces are trying to now meet.[29] In addition, provincial spending cuts in other social policy areas will also serve to increase the proportion of provincial spending going to health care.

Although the budget documents noted in Table 2 include a footnote stating that the final determination of the split of the chst will be made in future legislation, there has not been, as of yet, any federal commitment to consult with either Canadians or, it appears, the provinces, about the appropriateness of the split. This is in spite of the fact that the Social Union Framework Agreement (sufa) commits the federal government to providing sufficient notice to provinces (and presumably to the public) about significant changes in policies and programs that would have an impact on provincial programs and policies. While the budget documents might meet the standard of "sufficient notice" under the sufa, it seems that a policy choice with such far-reaching ramifications deserves something more in order to be seen as consistent with the spirit of the new intergovernmentalism that sufa was supposed to embody. Again, having secured some level of agreement on the destination, the federal government has chosen to steer while leaving the provinces to row.

What's left over: the Canada Social Transfer

Having secured provincial agreement to split the chst into its component parts and barring any reversal of course from the new prime minister, the federal government appears likely to forge ahead with imposing its own formulation of how the chst will be split and what it will comprise, namely cash and tax points.

Thus, the new Canada Social Transfer will be seen, at least notionally, as the federal contribution to provincial social spending and postsecondary education. According to the federal Department of Finance, the size of the cash portion of the cst in 2004–05 (the first year of the two new transfers) will be approximately $7.75 billion, or roughly thirty-eight per cent of the chst.[30] In its final year as a separate transfer (1994–95), the Canada Assistance Plan (cap) transferred $7.8 billion in cash to the provinces for social program spending alone. Of course, the federal government will also point to the apparent $6.8 billion in tax transfers it has allocated to the cst, making for a total of $14.55 billion. But, for the provinces (and perhaps for the public), it will be the cash that will count.

More importantly, what the cash component of the proposed cst indicates is the relative paucity of the federal transfer in support of *both* social assistance program spending and postsecondary education. The lack of direct federal support for these areas of provincial spending was effectively obscured during the chst era insofar as both politicians and the public were focused almost exclusively on the so-called "crisis in health care." A consequence of the coming split will be the ability of provincial governments, social policy activists and the public to point very clearly to the relative importance the federal government gives to these other areas of social and

educational policy programming. More problematically, the cst will cover a wide range of programs beyond postsecondary education and social assistance payments in the provinces, including specialized programs for children, civil legal aid, and the provision of social services beyond welfare. These important programs share no common policy goals and serve very different populations with different levels of political support and appeal.

What results under such a scenario is a replication of the intergovernmental debates over health care in the areas of social programming and postsecondary education

At the same time, provincial governments are clearly less than comfortable with the 38–62 split of the chst as proposed by the federal government. The federal rationale is that this represents the reality of provincial spending patterns in recent years. In other words, if you take the total health and social spending done by provinces (including own-source revenue plus federal transfers and equalization), they spend roughly sixty-two per cent of their social spending on health care. From a provincial perspective, of course, this kind of allocation fails to take into account some important factors that "explain" the ever-growing proportion of provincial budgets allocated to health care. In short, as federal cash transfers declined in the mid-1990s, provinces that were also trying to balance their budgets and reduce their debts resisted major cuts to health-care spending (for obvious political and good policy reasons) by transferring those cuts to other program areas – social spending, infrastructure, capital improvements, etc.

According to a report prepared by the four western finance ministers for the Western Premiers' Conference in June 2003, the federal government's method of allocating the chst between the cst and the cht will result, in effect, in moving money out of the social spending envelope in order to maximize the size of the health-care envelope:

> [F]ederal cash transfers for major social programming (cht plus cst) will be $20.5 billion in 2004/05, or $1.8 billion higher than in 1994/95 [before the chst was introduced]. This "net" increase is actually comprised of an *increase* in funding for health of $4.6 billion and a *reduction* in funding for post-secondary education and social services of $2.8 billion. In other words, about 60 percent of the increase in federal support for health care comes at the expense of its commitment to social services and post-secondary education.[31]

Thus, the cst has the potential to become something of a new flashpoint in intergovernmental relations. At present, the only apparent conditions on

the cst will be the pre-existing ban on residency requirements for receipt of social assistance benefits in the provinces. In the same way that calls for increases to the chst cash over the past years were met by calls from some quarters of the federal government (and indeed by some portion of both the public and the health policy community) for greater provincial "accountability" over how health-care dollars were being spent, so too will any provincial demand for increases to the cst cash raise the spectre of greater conditionality or more complete accounting of where and how cst dollars are being spent. What results under such a scenario is a replication of the intergovernmental debates over health care in the areas of social programming and postsecondary education.

What would make this debate different, however, is the relative position and political popularity of the different constituencies served by the cst. There is evidence to suggest that provincial social assistance rolls are increasingly made up of the long-term unemployed – individuals who tend to have lower levels of formal education and fewer marketable skills[32] that render them, regardless of the formal definition applied by provincial social-service ministries, relatively "unemployable" by virtue of their distance from the labour market. Historically, social assistance recipients have been subject to various forms of social regulation designed to reinforce their status as recipients of societal largesse[33] and must continually demonstrate that they are "deserving."[34] A recent examination of public perceptions of social assistance recipients in Saskatchewan confirms that contemporary attitudes are every bit as harsh as one would expect – characterizing social assistance recipients as "lazy" and "parasitical."[35]

On the other hand, postsecondary educational institutions are beacons of "advancement" that offer promises of increased opportunity, better jobs, and a myriad of both tangible and intangible rewards to those who attend as well as contributing to overall health and wealth of the population more generally. Access to postsecondary education epitomizes the "middle-class" dream of western liberal democratic states insofar as it promotes a mythology of being, perhaps, the last bastion of pure meritocracy. Thus, public anxiety about rising tuition costs, increased student loan debts and the overall quality of Canada's postsecondary institutions will likely resonate far more strongly with provincial governments than will concerns over the adequacy of social assistance programs. While it is unlikely that either the federal or provincial governments will want to either formally or informally apportion parts of the cst for specific programs or even broad policy categories, it seems equally likely that any demand for increases above those already contemplated by the federal government in their budget projections would be aimed at the more politically popular postsecondary education sector rather than social assistance – a replication of how the "crisis of health care" drove the debate over increases to chst cash levels in the late 1990s.

Unilateralism by other means: the federal social policy agenda

Even if the cst, with its relatively small amounts of cash being transferred with no serious conditionality, does not become a focal point for intergovernmental conflict, there is still a further source of fiscal tension between the two orders of government. As if anticipating the concern over the relatively small apportionment of the chst to social and education spending, the federal government's 2003 budget and the new prime minister's 2004 Speech from the Throne further highlight one of the more problematic trends in federal spending, namely the increased tendency of the federal government to bypass the provinces and spend directly in the areas of social programming and postsecondary education.

The 2003 budget allocated roughly $5 billion in direct or tax-based postsecondary education spending and almost $15 billion in social spending by the federal government over and above the amount currently transferred under the chst, equalization and Territorial Formula Financing. This includes the National Child Benefit ($8 billion), student loans, education savings plans, and educational tax credits ($3 billion), Employment Insurance Parental Benefits ($2.5 billion), First Nations education and social services ($2.5 billion), university-based research ($1 billion) and the Millennium Scholarship program ($500 million), with the remaining $2 billion split between a wide variety of programs for youth, the disabled, immigrants and other marginalized or in-need communities. This amounts to nearly 2.5 times the amount of cash to be transferred under the cst.

While the National Child Benefit (NCB), as the product of intergovernmental negotiations that built on existing provincial initiatives, may be immune from much intergovernmental conflict over federal intrusion into areas of provincial jurisdiction, some of this other program spending may well provoke increased provincial anxiety. To the extent that the federal government continues to place greater emphasis on direct and tax-based spending in what are unambiguously provincial jurisdictions, it runs the risk of exacerbating intergovernmental tensions and creating a new and troubling dynamic of competition between the two orders of government for credit for supporting these public spending priorities. Indeed, whereas the federal increases in health spending in recent years (the preferred term is "reinvestment") have been done almost entirely through increases to transfers to provinces, the increases in federal social and educational spending have been done almost entirely through direct spending and tax credits.

And, while the 2004 Speech from the Throne is careful to pay at least lip-service to the notion that "jurisdiction must be respected," it seems equally clear that the Martin government is planning to extend the Chrétien-era strategy of direct federal social spending over the heads of the provinces. Rather than engage the provinces directly in a debate over how much it

should transfer to provinces for non–health care social spending, it seems to be stepping up its strategy to go head-to-head with the provinces in specific policy realms by spending its own money on programs it designs and implements. Nowhere is this more explicit than in the postsecondary education sector where the federal Millennium Scholarship Fund, the Canada Research Chairs program, and the significant increases to the budgets of the Social Sciences and Humanities Research Council of Canada (sshrc), the Natural Sciences and Engineering Research Council of Canada (nserc) and the Canadian Institutes of Health Research (cihr) all demonstrate the increased federal presence in the sector – a presence that will allow it to claim at least some good portion of the credit for reversing the perceived "brain drain" from Canadian universities. And in the realm of social policy, the National Child Benefit – despite the criticism of some social policy analysts[36] – remains the jewel in the federal crown of social spending and its efforts to "invest" in children. Indeed, the new Martin government adds another dimension to this process with its oft-repeated promises to provide either funding or tax-relief (in the form of gst exemptions) to municipalities.

There is, though, an irony to this new spate of social spending that appears to be lost on the federal government. The various unilateral changes to the transfer regimes that began under Mulroney and reached their peak with the introduction of the chst were designed to extricate federal finances from provincial social spending. In creating its own set of direct transfers to citizens and municipalities, the federal government risks recreating the same kind of dependent relationship.

While there may be political credit to be won for creating programs such as the National Child Benefit or the Canada Research Chairs program, this credit diminishes over time and the programs become simply part and parcel of "what the government does." Any attempt to shift spending priorities or reallocate resources from those programs to others may come with a political price. Furthermore, federal interventions based on short-term funding initiatives, such as the three-year homelessness initiative, are unlikely to have much effect on serious social problems while also causing political upset when organizations and agencies have their funding cut as the program is wrapped up. That anger will be directed squarely at the federal government, and the federal government will not be able to shift blame to the provinces.

Block transfers to provinces may yield little in the way of political credit, but they maximize federal flexibility insofar as their dollars are not tied directly to specific programs – provincial governments pay the political price for closing hospitals, raising university tuition or cutting social spending. Thus, direct federal social spending may well create the kind of program dependency that the block transfer arrangements were themselves designed to avoid.

But as direct federal government social spending continues to increase, it will also exacerbate a growing tension between it and the provinces – namely, the persistence of a so-called "fiscal imbalance" between the two orders of government. Horizontal fiscal imbalances (i.e., the different fiscal capacities of the provinces to raise their own source revenue) are, to a significant degree, ameliorated by the constitutional commitment to equalization payments that redistribute monies from "have" to "have not" provinces. However, the focus of the intergovernmental debate is increasingly on the so-called "vertical fiscal imbalance" between the federal and provincial governments. In short, provinces have again begun to advance the proposition that their political ability to raise revenue through various forms of taxation are insufficient to meet their constitutional spending obligations for such high-cost programming as health, education and social policy. Concurrently, the federal government's seemingly permanent budget surpluses are a result of a revenue-raising capacity that far outstrips their obligations to spend money on services for Canadians. The solution, say some provinces, is to once again transfer tax points to the provinces in order to bolster their revenue such that it matches their spending obligations.

But the very notion of whether a "vertical fiscal imbalance" exists is clearly in the eye of the beholder – it is a concept rooted in politics rather than economics.[37] There is nothing that legally or constitutionally constrains a provincial government from raising more revenue on its own, although the political constraints on tax increases may be considerable. Similarly, should the federal government decide to massively increase defence spending or dramatically lower Employment Insurance premiums,[38] then the apparently "permanent" federal surpluses could disappear overnight. Of course, to the extent that the federal surpluses remain permanent there is always the option of spending that money directly in areas of provincial jurisdiction.

Thus, for some, the most coherent way in which to redress this apparent imbalance is to permanently transfer tax points to the provincial government in order to insure, first, that they have the fiscal capacity to meet their constitutional spending obligations and, second, that the federal government's capacity to spend unilaterally in provincial jurisdictions is reduced. This was the position staked out by Quebec's Commission on the Fiscal Imbalance, whose chair, Yves Séguin, is now the province's minister of finance.[39] But the argument for another tax-point transfer rests on a couple of fundamental but far from incontrovertible points. First, "health care" and "social policy" are exclusively provincial jurisdictions in which the federal government has no service-delivery role and should, therefore, turn its financing role over to the provinces. Second, whatever "national" dimensions exist in health and social policy – and they are demonstrably weaker in the latter than in the former – would be maintained at the insistence of pro-

vincial electorates who would not allow provincial governments to dismantle them.[40]

This first premise, at least with regard to health care and possibly with regard to other areas of social policy, is contestable. Insofar as health care extends beyond merely running hospitals and paying doctors to include the regulation of drugs, aspects of the criminal law and a host of other activities deriving from sections of the Constitution Act, 1867, other than section 92(7) (i.e., areas unambiguously assigned to the federal government), there is a federal role in health care that does not rest merely on the controversial use of the federal spending power – although the spending power is important to the federal role as it relates to services covered by the Canada Health Act.[41]

Canadians may not care deeply about the division of powers but they certainly understand the very important role that both orders of government play in different aspects of key policy areas and no more so than in health care

In other social policy areas, however, the federal government's role relies more heavily on the constitutionality of the federal spending power. Although there is no doubt about the spending power's constitutionality – similar provisions appear in virtually every federal constitution – there is legitimate concern about how and when it is exercised. The unwillingness of the federal government to acknowledge the need to restrain unilateral use of the spending power was a key factor in Quebec's refusal to sign the sufa.[42] And given the growing willingness of the federal government to engage in social policy development and spending, it may well be forced to justify this activity under the spending power.

For example, a recent Quebec Court of Appeal decision ruled that those aspects of the federal Employment Insurance program that are not directly related to involuntary unemployment (e.g., maternity and paternity benefits and the new compassionate leave program) were outside of the federal government's competence insofar as they went beyond the original intention of the 1940 constitutional amendment that added "unemployment insurance" to the list of federal powers.[43] Though undoubtedly on its way to the Supreme Court for a final decision, the argument that the federal government has extended its reach with regard to programs financed by the E.I. fund is a serious one that cannot be dismissed lightly. Should the federal government lose a final adjudication of this issue, it will have to fall back on the constitutionality of the spending power to justify not only these aspects

of the E.I. program but other aspects of its social spending as well. Such a move would only exacerbate the tensions with those provinces that have long sought to rein in the pernicious use of this federal prerogative and reinforce the belief that the federal government only accepts collaborative federalism on its terms.

The second premise justifying a further tax-point transfer relies on the as-yet untested belief that the provinces can build and sustain the national dimensions of health and social policy. It is true that most of the real innovations in social policy began as provincial experiments, and none is more famous than medicare's birth in Saskatchewan. But, medicare's national reach and its national dimensions rest with the willingness of the federal government to fund the replication of that experiment in nine other provincial laboratories.

But more important than the use of the spending power is how the national dimensions of medicare have come to define a particular conception of the Canadian community. It relies on what Keith Banting and Robin Boadway have called a particular definition of the "sharing community" as it relates to health and health care. That is, how do Canadians define the appropriate community that will share responsibility for policy directions in a particular area? What are the equity and efficiency considerations that make a particular policy area best served by decisions made locally, provincially or nationally? In the area of health care they argue,

> [T]he role of the federal government is rooted primarily in a commitment to a pan-Canadian definition of the sharing community, [although] efficiency considerations are also important in defining the balance between the federal and provincial governments. Decentralization has undoubted advantages that point to the desirability of local delivery of complex programs such as health services. However, decentralization can also generate important efficiency problems regarding the portability of benefits, fiscal competition among provinces, and fiscally induced migration. ... Thus, the debate about the federal role in health care does not simply pit equity against efficiency considerations. Capturing the benefits of both involves a judicious balancing in the federal-provincial division of labour.[44]

It could be countered, of course, that such reliance on perceptions of how we define "sharing community" easily leads to the dismissal of the importance of the division of powers that is evident in the 2004 Speech from the Throne or in the federal government's commitment to "what works" rather than a respect for jurisdiction and the federal principle. And, indeed, it can. But it can also lead to the kind of intergovernmentalism of which Ronald Watts wrote. In the same way that "what works" should not trump the division of powers, neither should we make a fetish out of any particular understanding of the division of powers.

Thus, propositions for another tax-point transfer to remove the federal

government, once and for all, from provincial jurisdiction rest not only on questionable assumptions about the division of powers but also on a misunderstanding of how Canadians want their federation to work. Canadians may not care deeply about the division of powers but they certainly understand the very important role that both orders of government play in different aspects of key policy areas and no more so than in health care.[45] Rather than this being seen as how little Canadians understand federalism, perhaps it should be understood as evidence of how well they understand it.

New dynamics, old outcomes?

Interestingly, the premiers, following their annual meeting in July 2003, appear to be developing a new strategy for dealing with the federal government. Following a proposal from the newly elected federalist government in Quebec, the premiers agreed to work towards the creation of a "Council of the Federation" that would be a forum for the development of common positions vis-à-vis the federal government. For some provinces – notably Quebec, Ontario and Alberta – the issue of the fiscal imbalance and the permanent transfer of fiscal capacity from Ottawa to the respective provincial capitals will be a key item on the council's agenda. Moreover, the premiers called for annual first ministers meetings in order to have a permanent forum in which the Council of the Federation can press its case to the federal government.[46]

Having come up short in the February 2003 Health Accord – both in fiscal and policy terms – both orders of government appear to have chosen to sharpen their swords rather than beat them into ploughshares

But, in policy terms, this most recent premiers meeting was again dominated by health-care issues, particularly the reluctance of some provinces – especially Alberta – to move forward on their earlier agreement to establish a national Health Council as recommended by the Romanow Commission. At the same time, the premiers expressed concern that the promised $2 billion in a one-time health-care transfer from the federal government may not be forthcoming insofar as it was predicated on a federal surplus that, in light of less than stellar economic growth, may not be as large as anticipated.

Interestingly, the premiers chose to refer to their positions – a Council of the Federation that excludes the federal government, the luke-warm endorsement of a national Health Council (with the proviso that its budget and mandate be tightly constrained), and their failure to recognize that they agreed that the $2-billion transfer was conditional on the state of federal

finances – as the ushering in of a new era of "constructive and cooperative federalism."[47]

Unfortunately, the annual premiers meeting failed to pick up on the position articulated earlier by the western premiers concerning how the CHST would be split in the coming years. As such, they may have missed an opportunity to insist that, in the interest of collaborative federalism, the federal government has an obligation to design the new transfer arrangements in conjunction with the provinces. Thus, the new spirit of "collaborative federalism" hailed by the premiers may be the beginning of some new level of interprovincial collaboration on some key issues (though the unanimity of this particular meeting was clearly of the lowest-common-denominator variety) but also a newly reinvigorated competitive federalism between the two orders of governments.

What appears to be taking shape is an increasingly contentious jockeying for position between Ottawa and the provinces in the guise of the Council of the Federation. As Ottawa chooses its own path in creating the new transfers and increases its own social spending independent of the provinces, the provincial governments – perhaps emboldened by the presence of the first federalist (and decidedly decentralist) government in Quebec in a decade – will try to make common cause through the council, whose mandate may well include bilateral relations with both the federal and state governments in the United States.

None of this bodes well for future directions in social and health policy. The Romanow report was premised on trying to build a more productive intergovernmental climate by finding an agreed-upon basis for the federal transfer such that the health-care debate could actually be about health care and the reforms needed to the system rather than simply about who pays how much and who is to blame for the decline in public confidence in the system. Having come up short in the February 2003 Health Accord – both in fiscal and policy terms[48] – both orders of government appear to have chosen to sharpen their swords rather than beat them into ploughshares.

Once again, the "social," or non-health-care, part of the intergovernmental agenda is getting shifted to the side as the first ministers focus on how to fill the so-called Romanow gap. Thus, the federal government can feel emboldened to continue in its course to use its fiscal capacity – for as long as it lasts – to unilaterally shape social policy according to its wishes without worrying much about how the provinces do or do not respond. As federal unilateralism persists it will make not only for more acrimonious intergovernmental relations but increasingly ineffective social policy as well. The new arrangements for managing intergovernmental relations and conflict being proposed – both the Council of the Federation and annual first ministers meetings – appear designed more as vehicles to intensify rather than resolve the disagreements.

The Canadian public has consistently both desired and been promised

more cooperation and less conflict in intergovernmental relations, especially when it comes to social- and health-policy interactions. But it seems that the federal government continues to read the public's acceptance of a federal role in social and health policy as a mandate for unilateral action – action that justifiably frustrates provinces and is undoubtedly behind the notion of the Council of the Federation. Having failed to curb Ottawa's unilateralism through vehicles such as the sufa, the provinces are moving towards trying to create a more united front against Ottawa's growing insistence on shaping social policy.

At the same time, the provinces risk reinforcing the perception that their only key interest is in increasing the size of the transfer and lessening the accountability for it. To the extent that the Council of the Federation focuses on the so-called "fiscal imbalance," with demands for more cash and more tax points, it runs the risk of being seen as an institutionalized version of the annual premiers demand for larger transfers from Ottawa. It may strengthen the position of the premiers (or at least amplify their voices), but it is not necessarily a harbinger of intergovernmental collaboration. Real collaboration, as Alain Noël has argued,[49] relies on a relationship between entities that see themselves as partners and as equals. It requires both a level of trust and respect that has been absent from the intergovernmental arena of late.

The final irony of the Chrétien era is that turning the intergovernmental agenda away from the constitutional concerns of the Trudeau and Mulroney administrations was supposed to lead to real progress on policies that mattered to Canadians. It was to be an era of what Lazar termed "non-constitutional renewal" of the federation in both governance and policy terms. But rather than renewal, there has been – with the doubtful exception of the National Child Benefit – few real policy innovations, and little to give Canadians much hope for future improvements. The new Martin administration, if its 2004 Speech from the Throne is any indication, appears only to have changed the style rather than the substance of federal policy directions. By seemingly missing much of the point of the Romanow report, both orders of government have chosen to retreat behind their respective battlements to prepare for the squirmishes to come.

Notes

1 Canada, Commission on the Future of Health Care in Canada [Romanow Commission], *Building on Values: The Future of Health Care in Canada. Final Report* [Romanow report] (Saskatoon: Commission on the Future of Health Care in Canada 2002), pp. 65–72.

2 Canada, Department of Health, *Health Care Renewal Accord 2003* [web site] ([Ottawa]: Crown Copyright, [2003]), at http://www.hc-sc.ca/english/hca2003/accord.html.

3 Alain Noël, "Without Quebec: Collaborative Federalism with a Footnote?," in Tom McIntosh, ed., *Building the Social Union: Perspectives, Directions and Challenges* (Regina: Canadian Plains Research Center, 2001), pp. 13–30.

4 Canada, Parliament, House of Commons, "Speech from the Throne" [Adrienne Clarkson],

Debates and Proceedings (Hansard), 37th Parliament, 3rd Session, 2 February 2004 (Ottawa: Public Works and Government Services Canada, 2004), p. 5.

5 Thomas J. Courchene, *A State of Minds: Towards a Human Capital Future for Canadians* (Montreal: Institute for Research on Public Policy, 2001).

6 Ronald L. Watts, "Managing Interdependence in a Federal Political System," in Thomas J. Courchene and Donald J. Savoie, eds., *The Art of the State: Governance in a World Without Borders* (Montreal: Institute for Research on Public Policy, 2003), p. 127 (emphasis in original).

7 Alain Noël, "Power and Purpose in Intergovernmental Relations," in Sarah Fortin, Alain Noël and France St-Hilaire, eds., *Forging the Canadian Social Union: SUFA and Beyond* (Montreal: Institute for Research on Public Policy, 2003), pp. 47–68.

8 Canada, Commission on the Future of Health Care in Canada (Romanow Commission), *Final Report*, Appendix E.1, p. 312.

9 Gerard W. Boychuk, "The Changing Political and Economic Environment for Health Care," in Gregory P. Marchildon, Pierre-Gerlier Forest and Tom McIntosh, eds., *The Fiscal Sustainability of Health Care in Canada, The Romanow Papers: Volume I* (Toronto: University of Toronto Press, 2004), pp. 320–39; and Louis Imbeau, Kina Chenard and Adriana Dudas, "The Conditions for a Sustainable Public Health System in Canada," in Tom McIntosh, Gregory P. Marchildon and Pierre-Gerlier Forest, eds., *The Governance of Health Care in Canada, The Romanow Papers: Volume III* (Toronto: University of Toronto Press, 2004), pp. 224–53.

10 Harvey Lazar, France St-Hilaire and Jean-François Tremblay, "Vertical Fiscal Imbalance: Myth or Reality?," and "Federal Health Care Funding: Toward a New Fiscal Pact," in Harvey Lazar and France St. Hilaire, eds., *Money, Politics and Health Care: Reconstructing the Federal-Provincial Partnership* (Montreal and Kingston: Institute for Research on Public Policy and Institute of Intergovernmental Relations, 2004), pp. 135–87 and 189–228, respectively.

11 One of the most striking, and important, features of the work by Lazar, St-Hilaire and Tremblay, as noted above, is the detailed analysis of how much the federal government contributed to the development of the provincial health-care systems as a percentage of those systems' costs. Though operating on somewhat different assumptions than the analysis outlined in Appendix E of the Romanow report, they provide a comprehensive demystification of a debate that has, in the past, yielded more heat than light.

12 Gregory P. Marchildon, *Medicare and Federal Leadership: Decision Time ... Still!* (Toronto: Caledon Institute, forthcoming).

13 Réjean Pelletier, "Intergovernmental Cooperation Mechanisms: Factors for Change?," and Candace Redden, "Health Care Politics and the Intergovernmental Framework in Canada," in McIntosh, Forest and Marchildon, *The Romanow Papers, Volume III*, pp. 127–68 and 199–223, respectively.

14 Matthew Mendelsohn, *Canadians' Thoughts on their Health Care System: Preserving the Canadian Model Through Innovation* (Saskatoon: Commission on the Future of Health Care in Canada, 2002).

15 Richard Wilkinson and Michael Marmot, eds., *The Social Determinants of Health: The Solid Facts*, 2nd edition (Geneva: World Health Organization, 2003).

16 Saskatchewan, Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* [Fyke report] (Regina: Saskatchewan Health, 2001); Alberta, Premier's Advisory Council on Health, *A Framework for Reform. Report* [Mazankowski report] (Edmonton: Premier's Advisory Council on Health, 2001); and Quebec, Commission d'étude sur les services de santé et les services sociaux. *Emerging Solutions: Report and Recommendations* [Clair report] (Quebec: Ministry of Health and Social Services, 2001).

17 Canada, Parliament, Senate, Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Volume Six: Recommendations for Reform* [Kirby report] (Ottawa: Public Works and Government Services Canada, 2002), p. 264 (emphasis added).

18 Ibid., p. 292.
19 A fuller discussion of the rationale of why the Romanow Commission rejected hypothecated or dedicated taxes can be found in Marchildon, *Medicare and Federal Leadership* (forthcoming).
20 Canada, Commission on the Future of Health Care in Canada (Romanow Commission), *Final Report*, p. 65.
21 Ibid., p. 31.
22 Ibid., p. 69.
23 Ibid.
24 At the same time, as the 2003 budget documents indicate, the federal government remains committed to the inclusion of the value of the tax points in the calculation of the transfer. Unfortunately, this may well mean that the ability of Canadians to get an unambiguous answer to the question of who is paying how much towards the health-care system and towards other social spending will remain impaired.
25 Of course, not all of the recommendations in either the Senate or Romanow reports were about expanding services. It can be argued, for example, that the recommendation that both reports make for the inclusion of post-acute home care under the Canada Health Act is not so much an expansion of the system as the "re-insuring" of individuals who have been, for both technological and other reasons, de-insured for services (e.g., nursing, pharmaceuticals and rehabilitation) previously provided in hospitals.
26 Mendelsohn, *Canadians' Thoughts on their Health Care System*.
27 Judith Maxwell, Karen Jackson, Barbara Legowski, Steven Rosell and Daniel Yankelovish (in collaboration with Pierre-Gerlier Forest and Larissa Lozowchuk), *Report on Citizens' Dialogue on the Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada), pp. 58–64; and Karen Jackson, Sandra Zagon, Richard Jenkins and Joe Peters (in collaboration with the Commission on the Future of Health Care in Canada), *Public Input on the Future of Health Care: Results from the Consultation Workbook* (Saskatoon: Commission on the Future of Health Care, 2002), pp. 47–8.
28 Cf. Canada, Department of Finance, *The Budget in Brief 2003* (Ottawa: Her Majesty the Queen in Right of Canada, 2003); and Canada, Department of Finance, *Budget 2003: Investing in Canada's Health Care System* (Ottawa: Her Majesty the Queen in Right of Canada, 2003).
29 Boychuk, "The Changing Political and Economic Environment for Health Care," in Marchildon, Forest and McIntosh, *The Fiscal Sustainability of Health Care in Canada*, pp. 320–39.
30 Canada, Department of Finance, *Budget 2003: Investing in Canada's Health Care System*, Table 5, p. 25.
31 Canada's Western Premiers' Conference, *Federal/Provincial/Territorial Fiscal Relations in Transition: A Report to Canada's Western Premiers' Conference from the Finance Ministers of British Columbia, Alberta, Saskatchewan, Manitoba, Yukon, Northwest Territories and Nunavut* (Victoria: Canada's Western Premiers' Conference, 2003), p. 5 (emphasis in the original).
32 Tom McIntosh and Gerard W. Boychuk, "Dis-Covered: Employment Insurance, Social Assistance and the Growing Gap in Income Support for the Unemployed," in Tom McIntosh, ed., *Federalism, Democracy and Labour Market Policy in Canada* (Kingston: School of Policy Studies, Queen's University, and McGill-Queen's University Press, 1999), pp. 72–5.
33 Margaret Little, *No Car, No Radio, No Liquor Permit: The Moral Regulation of Single Mothers in Ontario, 1920--1997* (Don Mills, Ont.: Oxford University Press, 1998).
34 Boychuk, "The Changing Political and Economic Environment for Health Care," in Marchildon, Forest and McIntosh, *The Fiscal Sustainability of Health Care in Canada*, pp. 320–39.
35 Robert Wartaugh, *Productivity and Popular Attitudes Toward Welfare Recipients in Saskatchewan, 1970–1990*. Public Policy Paper 14 (Regina: Saskatchewan Institute of Public Policy, 2003).
36 See Gerard W. Boychuk, "Social Union, Social Assistance: An Early Assessment," in Tom McIntosh, ed., *Building the Social Union*, pp. 51–67; and James P. Mulvale, *Reimagining Social Welfare: Beyond the Keynesian Welfare State* (Toronto: Garamond Press, 2001).

37 Havey Lazar, France St-Hilaire and Jean-François Tremblay, "Vertical Fiscal Imbalance: Myth or Reality?," in Lazar and St-Hilaire, *Money, Politics and Health Care: Reconstructing the Federal-Provincial Partnership*, pp. 135–87.

38 It should be noted that federal government's surpluses through much of the later 1990s were in fact fuelled by the billions of dollars collected through Employment Insurance premiums over and above the specific needs of the program itself.

39 Quebec, Commission on Fiscal Imbalance [Séguin Commission], *Fiscal Imbalance: Problems and Issues* (Quebec: Gouvernement du Québec, 2001).

40 Marchildon, *Medicare and Federal Leadership*, forthcoming.

41 André Braën, "Health and the Distribution of Powers in Canada," and Howard Leeson, "Constitutional Jurisdiction over Health and Health Care Services in Canada," in McIntosh, Forest and Marchildon, *The Governance of Health Care in Canada*, pp. 25–49 and 50–82, respectively.

42 Cf. Alain-G. Gagnon and Hugh Segal, eds., *The Canadian Social Union Without Quebec – 8 Critical Analyses* (Montreal: Institute for Research on Public Policy).

43 *Québec (Procureur général)* c. *Canada (Procureur général)*, [2004] Q.C.C.A. 200-09-003962-021 (2004-01-27).

44 Keith Banting and Robin Boadway, "Defining the Sharing Community: The Federal Role in Health Care," in Lazar and St-Hilaire, *Money, Politics and Health Care*, p. 75.

45 Mendelsohn, *Canadians' Thoughts on their Health Care System*.

46 Canadian Intergovernmental Conference Secretariat, *News Release: Premiers Announce Plan to Build New Era of Constructive and Cooperative Federalism* [10 July 2003, Ref: 850-092/006] ([Ottawa]: cics, [2003]), at http://www.scics.gc.ca/cinfo03/850092006_e.html.

47 Ibid.

48 On the surface, the 2003 Health Accord appears to go a long way towards the implementation of the Romanow report. However, if the agreement is read carefully, it soon becomes apparent that while all the right signals are there, the accord comes up short in terms of real commitments. Romanow called for limited time targeting of the new cash in those areas where governments and the public most wanted reform. The rationale was, as the saying goes, " to buy change" in the system. But, the accord only identifies those areas as "priorities" without making those investments a condition of receipt of the cash. As a result, the system will likely absorb the new dollars without changing how services are delivered and organized. And, provincial governments can blame the failure to "buy change" on the federal government's unwillingness to provide the full amount Romanow called for – the so-called "Romanow Gap."

49 Noël, "Without Quebec," in McIntosh, *Building the Social Union*, pp. 13–30.